ADAM P. CRAMER, DDS
ADVANCED FAMILY & COSMETIC DENTISTRY

NEW PATIENT REGISTRATION

Patient: ____ Preferred Name: ______________________
Last Name First Name Middle Initial

Home #: ______________________ Work #: ______________________ Cell #: ______________________

Email Address: ____

Home Address: ____

City: ______________________________ State: __________ Zip: ____________________

DOB: _____ /_____ /_______ Social Security #: ____________________ □ Male □ Female / □ Single □ Married
MM DD YYYY

Employer: ______________ Spouse Name: ______________ Spouse's Employer: ______________

Alternate Contact (Outside of Home/Spouse): ____________________________________

Who can we thank for referring you to our office? ____________________________________

PERSON RESPONSIBLE FOR ACCOUNT: ____________________ Address: ____________________

Method of Payment (After Insurance Payments): □ Cash/Check □ Credit Card □ Third Party Financing

PRIMARY DENTAL INSURANCE:

Insurance Company Name: ____

Subscriber's Name: ______________________________________ DOB: _____ /_____ /_______

Group # ____________________________ ID# ____________________________

SECONDARY DENTAL INSURANCE:

Insurance Company Name: ____

Subscriber's Name: ______________________________________ DOB: _____ /_____ /_______

Group # ____________________________ ID# ____________________________

MEDICAL INSURANCE:

Insurance Company Name: ____

Subscriber's Name: ______________________________________ DOB: _____ /_____ /_______

Group # ____________________________ ID# ____________________________

I authorize treatment by Dr. Cramer, Dr. Bond, and/or Dr. German and agree to pay all related professional fees. Fees not covered by my dental/medical insurance will be promptly paid upon notification from this office. I have received a copy of the office's financial policy and without reservation I agree to abide by the policies outlined herein.

Signature: ______________________________________ Date: ____________________

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Adam P. Cramer, P.C. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Adam P. Cramer, P.C. reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:	☐ **YES**	☐ **NO**
Name of patient (please print):		
Patient signature (if 18 years old or older):		
Patient's personal representative: (Please Print):		
Personal Representative's signature:		
Representative's Telephone Number: **Date:**		

FOR OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining Patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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HEALTH HISTORY FORM

Patient Name: ______________________________ Date of Birth: ______________

Physician's name, phone, and date of last exam: ______________________________

Yes **No** Do you take medications? If so, please list: ______________________________

____

Yes **No** Do you have allergies (Penicillin, Codeine, Latex, etc.)? If so, please list: ______________________________

Yes **No** Have you been hospitalized? If so, please list dates and reasons: ______________________________

Do you have or have you ever had any of the following (if "Yes", please circle which):

Yes **No** Artificial joints (hip, knee, etc.)
Yes **No** High blood pressure / Angina / Arrhythmias
Yes **No** Heart disease / Heart attack / Defibrillator
Yes **No** Artificial heart valve / Pacemaker
Yes **No** Bleeding disorders / Prolonged bleeding
Yes **No** Anemia / Leukemia / Blood dyscrasias
Yes **No** Stroke / Aneurysm
Yes **No** Seizures
Yes **No** Hepatitis / Liver disease / Kidney problems
Yes **No** HIV / AIDS
Yes **No** Ulcers / Stomach problems
Yes **No** Osteoporosis / Bone disease
Yes **No** Diabetes / Family History of Diabetes
Yes **No** Thyroid / Adrenal problems
Yes **No** Periodontal (gum) disease
Yes **No** Family history of periodontal disease
Yes **No** Cancer / Tumors
Yes **No** Chemotherapy / Radiation treatment
Yes **No** Sinus problems / Ear problems
Yes **No** Asthma / Tuberculosis / Lung disease
Yes **No** Arthritis / Lupus
Yes **No** Anxiety / Depression / Psychiatric treatment
Yes **No** Dental anxiety
Yes **No** Sleep Apnea
Yes **No** TMJ Pain / Disorder
Yes **No** Tobacco use
Yes **No** Drug / Alcohol abuse
Yes **No** Currently Pregnant / Nursing

Yes **No** Any other medical problems? If so, please describe: ______________________________

Yes **No** Do you prefer some form of sedation for dental procedures? If "Yes", please circle which

Nitrous oxide (laughing gas) Oral sedation IV sedation

Yes **No** Is there anything you would like to change about your smile/teeth? ______________________________

How often do you: brush your teeth______________ floss your teeth____________

To the best of my knowledge, I have filled out this Health History Form completely and accurately.

Patient / Guardian Signature: ______________________________ Date: ______________

Hygienist/Assistant Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________

Revised: 08/03/2013

APNEA SCREENING QUESTIONNAIRE

This questionnaire helps to determine your risk for having sleep apnea.

	YES	NO	NOT SURE
Have you ever had a sleep study?	◻	◻	◻
Are you currently using a CPAP device?	◻	◻	◻

	YES	NO	NOT SURE
Have you been told that (or noticed on your own) that you snore on most nights?	◻	◻	◻
Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?	◻	◻	◻
Are you tired, fatigued or sleepy on most days?	◻	◻	◻
Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions?	◻	◻	◻
Are you overweight?	◻	◻	◻
Do you have diabetes?	◻	◻	◻
Have you ever been told you have any of the following?: ▪ Congestive Heart Failure ▪ Coronary Artery Disease ▪ Irregular Heart Rhythms (atrial fibrillation) ▪ Stroke	◻	◻	◻

Internal Office Notes:

Height: ____________ *Weight:* _____________ *BMI:* ____________ *Neck Circumference:* _________________

Insurance: ________________________ *Requires Prior Auth.? Y / N* *Screener Score:* ____________________